Senate Commerce, Labor and Agriculture Committee 1

Amendment No. 1 to SB0549

Stanley
Signature of Sponsor

AMEND Senate Bill No. 549* House Bill No. 793

by deleting all language after the enacting clause and by substituting instead the following:

SECTION 1. Tennessee Code Annotated, Section 56-7-110(a), is amended by deleting subdivision (6) in its entirety and by renumbering subsequent subdivisions accordingly;

SECTION 2. Tennessee Code Annotated, Section 56-7-110, is amended in:

(1) Subsection (c) by deleting the language “retroactively deny” and by substituting instead the word “recoup”;

(2) Subsection (d) by deleting the language “retroactively denies,” and by substituting instead the word “recoups”, and by deleting the language “retroactive denial” and by substituting instead the word “recoupment”;

(3) Subsection (e) by deleting the language “retroactively deny” and by substituting instead the word “recoup”; and

(4) Subsection (f) by deleting the language “retroactively deny” and by substituting instead the word “recoup”, and by deleting the language “retroactive denial” and by substituting instead the word “recoupment”.

SECTION 3. Tennessee Code Annotated, Section 56-7-110(g), by deleting the phrase “under a retroactively denied claim;”.

SECTION 4. Tennessee Code Annotated, Section 56-7-110(j), by deleting the subsection in its entirety and substituting instead the following:

(j) This section shall not be waived, voided or nullified by contract, provided however, that the health insurance entity and the health care provider

are permitted to toll the time periods contained in subsections (c) and (f) through mutually negotiated and separate tolling agreements if both parties agree to toll or extend the time periods established by subsections (c) and (f).

SECTION 5. Tennessee Code Annotated, Title 56, Chapter 7, Part 1, is amended by adding the following as a new appropriately designated section:

Section 56-7-1_____

(a) As used in this section only, the following terms have the meaning as indicated:

(1) “Original health insurer” means a health insurance entity as defined in § 56-7-109 that has verified eligibility for the date of service, or as required has communicated to a health care provider prior authorization or pre-certification for a service to be provided, to a person believed by the original health insurer to be covered under such group health care policy as of the date that eligibility was verified or prior authorization or pre-certification is issued, but which no longer covers the insured individual at the time the service is performed.

(2) “Successor health insurer” means a health insurance entity as defined by § 56-7-109 that provided group health coverage for the person at the time the original health insurer verified eligibility or approved prior authorization or pre-certification for the person or at the time the service was actually performed.

(3) “Successor coverage health claim” means a claim for benefits or reimbursement under a group health care policy when the health care services performed were based upon verification of eligibility or were authorized by an original health insurer, but the original health insurer coverage has been replaced by a successor health insurer on or before the date that the services are provided to the covered person.

(b) In the case of a successor coverage health claim, and notwithstanding the provisions of a successor health insurer group health care policy:

(1) A successor health insurer shall not deny a claim because of failure to submit the claim timely, provided the claim was submitted within one hundred eighty (180) days of the date the claim was denied by the original health insurer; and

(2) A successor health insurer shall not deny the claim because of the covered person's failure to obtain prior authorization or pre-certification, if the successor insurer would have granted prior authorization or pre-certification for the service had it been asked to do so prior to the health care service being rendered to the covered person.

(c) Except as may result from the application of subsection (b), nothing in this section shall require a successor health insurer to pay any claim or make reimbursement for any services not covered under the terms of its group health care policy.

(d) This section shall not apply to TennCare or any successor program provided for in title 71, chapter 5; or CoverKids or any successor program provided for in title 71, chapter 3, part 11.

(e) Nothing in this section shall create any obligation by an original health insurer to a successor health insurer to provide proof of eligibility inquiry by a health care provider.

SECTION 3. Tennessee Code Annotated, Title 56, Chapter 7, Part 1, is amended by adding the following as a new appropriately designated section:

Section 56-7-1_____

A policy of group accident and health insurance as defined in § 56-26-201 that is issued to an employer shall contain a provision requiring the employer to notify the insurer when any person covered under the

group policy ceases to be eligible for coverage. The employer shall notify the health insurer of a covered person's loss of eligibility within the time set forth in the contract, but in no event shall such notification occur more than sixty (60) days after the employer learns of a covered person's loss of eligibility.

SECTION 4. This act shall take effect October 1, 2009, the public welfare requiring it